I: Summary of the Anti-Kickback Statute

The Anti-Kickback Statute: Prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. See 42 U.S.C. § 1320a-7b.

As written, the statute required that in order for a violation to be shown:

- A person or entity must commit an “Intentional Act” (knowingly and willfully).
- Which constitutes the direct or indirect solicitation or receipt of “Remuneration” (virtually anything of value).
- Intended to induce the “Referral of Medicare / Medicaid Payments or Business.”
I: Summary of the Anti-Kickback Statute

- The “Affordable Care Act” of 2010 strips away much of what Congress intended with its amendments of 1980.

Prior to the passage of the Affordable Care Act, the federal circuit courts had issued differing opinions regarding the definitions of “knowingly” and “willfully” under the Anti-Kickback Statute.

While several courts required the government to prove that a defendant “knew” that the Anti-Kickback Statute prohibited the conduct at issue, other courts disagreed, saying that actual knowledge was not necessarily required.

Under the Affordable Care Act, it is now clear that the Anti-Kickback Statute does not require the government to prove “Actual Knowledge” that a known legal duty was being violated. Moreover, “Specific Intent” is no longer required.

What level of knowledge and intent is now required?

II: State and Private Payor Concerns

- Providers must be careful to ensure that they adhere to state Anti-Kickback laws. Most states have also passed legislation criminalizing improper kickbacks and patient solicitation. For instance, the state of Texas has passed an anti-solicitation statute which is exceptionally broad. The statute applies to any person, including private payors. The statute provides:

  “A person commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency.”

  Tex. Occ. Code 102.001(a).

- In addition to this broad prohibition, Texas also has a specific statute which makes it illegal to engage in kickback-type activity in connection with Medicaid items and services. The statute reads:

  “A person commits a violation if the person:
  ....
  solicits or receives, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program.”


- Both participating and non-participating providers must keep in mind that improper claims submitted to private payors may subject a practice to breach of contract claims and/or allegations of fraud. For example, the American Medical Association (AMA) has published the following guidance:

  “Opinion 6.12: Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private. Other insurers may permit forgiveness or waiver of copayments, but may consider fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers. A physician commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency.”

  Please note: The AMA recently updated its Ethics Opinions. The newest version of this Opinion does not address waiver issues.

- The submission of false claims to private payors may constitute a violation state and/or federal law.
III: Safe Harbors

• The “Medicare and Medicaid Patient and Protection Act of 1987” included specific direction to HHS regarding the development of “Safe Harbors.” As set out under 42 C.F.R. §1001.952, a total of 25 safe harbors have been established.

• Safe Harbors are intended to: Allow for certain non-abusive business practices and arrangements to occur even though, on their face, the practices and arrangements would violate the Anti-Kickback Statute. “Safe Harbor” protection is only afforded to specific conduct that does not pose a significant threat to the Medicare / Medicaid programs.

• “Discount Safe Harbor”

  “Safe harbors relating to discounts, employees and group purchasing organizations are specifically required by statute. The discount exception was intended to encourage price competition that benefits the Medicare and Medicaid programs. The proposed discount provision was limited in application to reductions in the amount a seller charges for a good or service to the buyer. The discount could take the form of a specified price break, or the inclusion of an extra quantity of the item purchased “at no extra charge.” We did not propose to protect many kinds of marketing incentive programs such as cash rebates, free goods or services, redeemable coupons, or credits.”

IV: Examples of Improper Kickbacks

• Kickbacks can take a wide variety of forms, some of which are more easily discernible than others. For instance, the giving of cash payments in exchange for referrals is a violation of law that is easily recognized by health care providers. In contrast, a lease arrangement whereby space is offered by a health care provider lessor at less than market value to a potential referral source may be slightly less obvious in appearance but is nonetheless a likely violation of law. Such lease agreements and other similar business arrangements are sometimes referred to as “disguised kickbacks.”

• More complicated situations encountered. These include those where one or more legitimate purposes for a business arrangement may be cited but a less apparent reason for the arrangement is that it serves as an incentive to refer patients to one of the parties. Importantly, courts have consistently held that if even one purpose of the arrangement was to obtain something of value in exchange for referrals, the arrangement is a violation of the federal Anti-Kickback Statute. This is commonly referred to as the “One Purpose Rule.” As the Court in Greber held: “If one purpose of the remuneration is to induce referrals, the statute is violated, even if the payment was also intended to compensate for professional services” (emphasis added).

IV: Examples of Improper Kickbacks

• Possible examples of illegal kickbacks could include:

  "A wheelchair supplier pays a physician approximately $200 for each prescription issued to a Medicare beneficiary ordering an electric wheelchair from the supplier. Notably, medical necessity would not even be a factor in such a case – the mere payment by the supplier for each referral would directly violate the statute."

  "A physician who rents out excess space in his office building (at less than fair market value) to another physician who regularly refers Medicare patients to the landlord-physician for ENT care and treatment."

  "An orthopedic device manufacturer pays a surgeon $50,000 to serve as a “consultant” to the company with respect to its products. The surgeon hired is also one of the highest users of the manufacturer’s products. Other than attend several expensive dinners, no consulting work of any real value was ever performed by the surgeon."

  "A physician offers to provide discounted care and treatment to an uninsured patient in exchange for the patient’s referral of several family members covered by Medicare to the treating physician."
V: Questions to Ask When Assessing a Business Arrangement

- Questions to ask when assessing a business arrangement:
  - What is the business nature of each party in a proposed business arrangement?
  - Do any of the parties in the proposed business arrangement currently conduct business with each other?
  - Do the parties currently refer health care business to one of the other parties to the proposed business arrangement?
  - Under the proposed business arrangement, will one or more parties actually refer or have the potential to refer health care business to another party in the arrangement?
  - What types of value may or could be paid, referred, recommended, or offered from one party to another in the arrangement, either directly or indirectly?
  - To what extent are health care items, supplies, or services provided by any party to the agreement covered, billed, or reimbursed by a federal or state funded health care program?
  - Under the proposed business arrangement, is it anticipated that there will be:
    - An increase in the overall cost of health care services?
    - A decrease in a beneficiary’s access to health care services?
    - A decrease in the quality of care provided to beneficiaries?
    - A decrease in the number of overall providers a beneficiary may choose from when obtaining health care services?
    - A less competitive marketplace between competing health care providers?
    - A decreased ability of underserved beneficiaries to obtain health care services?
    - A negative impact, of any type whatsoever, on the Medicare Trust Fund?

VI: Professional Courtesy / Waivers: Federal Anti-Kickback and False Claims Act Concerns

- Professional courtesy / Waiver of co-payments and deductibles. The term “Professional Courtesy” refers to the provision of medical care or services to another health care provider or his or her family for free or at a reduced rate. The extension of professional courtesy is a long-standing practice among health care providers. Historically viewed as a benefit that is often extended between professional peers, this practice is still quite prevalent, despite the fact that such conduct can be problematic or even illegal, depending on the facts.

- Importantly, there is no “safe harbor” under the federal Anti-Kickback Statute covering professional courtesy. Moreover, extending professional courtesy when the payor is a federal health benefits program will in all likelihood constitute a violation of the federal Anti-Kickback Statute. HHS-OIG has long warned providers that the “routine waiver” of co-payments and deductibles can be prosecuted as a violation of the statute.

- As set out in HHS-OIG’s 1994 Special Fraud Alert: “...anyone who routinely waives copayments or deductibles can be criminally prosecuted under 42 U.S.C. 1320a-7(b)(5), and excluded from participating in Medicare and the State health care programs under the anti-kickback statute, 42 U.S.C. 1320a-7(b)(7).”

- This type of misleading behavior was recognized by HHS-OIG in its 1991 Special Fraud Alert. As the 1991 Special Fraud Alert provides:

  “Since October 1, 1983, when the prospective payment system (PPS) for reimbursing hospital inpatient services was implemented, we have been aware of hospitals that routinely waive Medicare beneficiary deductibles and coinsurance charges for inpatient hospital services in order to attract patients. Because the waiver of patient charges constitutes an inducement to use services in exchange for something of value (the forgiveness of financial obligation), this practice violates the statute” (emphasis added).
VI: Professional Courtesy / Waivers: Federal Anti-Kickback and False Claims Concerns

- In 1994, HHS-OIG issued an additional fraud alert pertaining to waiver of co-payments and deductibles and the following statement was made:

  "Routine waiver of deductibles and co-payments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare." (December 19, 1994).

- Exceptions to the waiver prohibition. Medicare patients are not responsible for payment of the Medicare deductible for services for which the provider has been determined to be liable, such as in cases when it is not medically necessary. Additionally, Medicare patients are not responsible for deductibles when dealing with certain specific services, such as the donation of a kidney for transplant surgery, pneumococcal and influenza vaccinations, and pap tests and pelvic exams.

- Exceptions are also made for managed care cases. Under certain circumstances, managed care organizations that waive deductibles or co-payments are protected from anti-kickback liability under a safe harbor, and such protection is seen as an incentive to encourage enrollment with health plans under a Centers for Medicare and Medicaid Services (CMS) authorized contract.

VI: Professional Courtesy / Waivers: Federal Anti-Kickback and False Claims Act Concerns

- Are discounts for “prompt payment” permitted?

  - HHS-OIG has indicated in at least one Advisory Opinion that it would permit prompt pay discounts if:
    1. Amount of discount relates to cost to collect.
    2. Offered to all patients for all services/items, regardless of diagnosis, length of stay/treatment, etc.
    3. Not advertised.
    4. Costs are not shifted to Medicare, Medicaid or other government programs
    5. Private payers are notified.

  See: Advisory Opinion 08-03; 56 Fed Reg 35952 (AKS Safe Harbors regulation)

  - Be careful, providing a prompt payment discount may affect “usual and customary charges” under private payer contracts.

VI: Professional Courtesy / Waivers: Federal Anti-Kickback and False Claims Act Concerns

- Examples of improper, routine waivers of co-payments and deductibles. The following practices have been identified by HHS-OIG as examples of improper, routine waivers of co-payments and deductibles:
  1. Advertising no out of pocket expense;
  2. Advertising that insurance is accepted as payment in full;
  3. Advertising discounts for Medicare beneficiaries;
  4. Using beneficiary financial hardship forms routinely with no good-faith effort to ascertain actual financial condition;
  5. Collecting co-payments and deductibles only when the patient has supplemental insurance coverage by Medicare;
  6. Charging Medicare patients a higher amount than non-Medicare patients for similar services;
  7. Failing to collect co-payments or deductibles for any group of Medicare patients for reason other than extreme poverty or financial constraint; and
  8. Covering co-payments or deductibles for services provided by the same entity that offers insurance for which the premium is insignificant and not based on actuarial risk.
VI: Professional Courtesy / Waivers: Federal Anti-Kickback and False Claims Act Concerns

- **Allowable waivers.** The government will permit waivers in the event that the beneficiary’s case is individually reviewed and generally fits the following criteria:
  
  1. It is not offered as a part of any advertisement;
  2. The person waiving the co-payment or deductible does not do this routinely; and
  3. There is a good faith determination that the beneficiary is in financial need, or that the person making the waiver fails to collect after making reasonable collection efforts.


- **Professional courtesy / Waiver of co-payments and deductibles.** A number of professional associations have addressed the issue of professional courtesy. For example, the American Medical Association (AMA) has published the following guidance:

  "**Opinion 6.13 - Professional courtesy.** Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insured payments while waiving patient copayments may conflict Opinion 6.12, "Forgiveness or Waiver of Insurance Copayments" (emphasis added)."

- The AMA’s opinion tracks that of HHS-OIG. While Ethical Opinion 6.13 may initially appear to suggest that the AMA has not really taken a firm position on this issue, a review of Ethical Opinion 6.12 clearly shows otherwise. As Ethical Opinion 6.12 reflects, the AMA’s position directly tracks the guidance issued by HHS-OIG. The routine waiver of co-payments, even if the co-payments are owed by a professional peer or an associated family member, would likely be a violation of federal and/or state law (in all likelihood, the anti-kickback statutes) if the payor is a federal or state plan. If the payor is private, the waiver likely constitutes a contractual breach by the participating provider.

- It is often left to you to advise your physicians on professional courtesy issues. Despite the fact that the provision of professional courtesy remains widespread in many communities, as a practice manager (or possibly even a third-party biller), it is often left to you to advise the physicians and other health care providers in your organization of the significant risks involved. In order to bring a kickback case based on the extension of professional courtesy, the government will only have to show that one purpose for the provision of professional courtesy was to induce the referral of federal health care program business. Most typically, this would take the form of Medicare and/or Medicaid patient referrals from another health care provider to your practice. In light of recent changes to the law which reduce the levels of "knowledge" and "intent" needed to prove that a violation has occurred, the best practice is to not extend professional courtesy to anyone, period.

- Does prohibiting professional courtesy prohibit the provision of discount or free care? To be clear, prohibiting professional courtesy does not mean that free or discounted services cannot be provided to worthy patients. As set out below, the government recognizes the benefit of providing free or discounted care to patients who properly qualify for such care, once "need" has been established.
VII: Civil Monetary Penalty and Stark

- Referrals of patients for “designated health services” may violate Stark. Under Stark, a physician is prohibited from referring Medicare and Medicaid patients for “designated health services” to any entity with which the physician and his or her immediate family members have a “financial relationship.” Importantly, the term “financial relationship” is intended to be broadly interpreted and covers both: (1) direct and/or indirect “ownership or investment interests” in the entity that furnishes the designated health service, and (2) any “compensation arrangement” between the physician and the entity to whom the referral is made. However, there are certain instances, known as exceptions, in which a relationship technically in violation of Stark may be allowed.

- Stark and “professional courtesy.” In recognition of the long-standing tradition and widespread practice of extending professional courtesy to physicians and their families, “Phase II” of Stark (a major amendment to the law) creates an exception allowing entities to extend “professional courtesy” to a physician, members of the physician’s immediate family, or members of the physician’s office staff pursuant to several conditions. In addition to other conditions, if the professional courtesy policy involves the reduction in coinsurance, the entity must notify the insurer in writing of the reduction. Moreover, the professional courtesy cannot be offered to a physician (or immediate family member) who is a federal health care program beneficiary, unless there has been a good faith showing of financial need. See 42 CFR § 411.357(s).

VII: Civil Monetary Penalty and Stark

- Waiving copays or deductibles may constitute a violation of the Civil Monetary Penalties laws. There is a prohibition on transferring or offering “remuneration” to federal program beneficiaries, if provider knew or should have known that remuneration would make it likely that patient would order or receive items or services payable by federally funded healthcare programs from that provider.

- Specifically defines “remuneration” to include waiver of copays and deductibles.

- Potential penalties for a CMP violation include:
  - $10,000 per item or service provided.
  - Treble damages.
  - Repayment of amounts received.
  - Exclusion.

VIII: Provision of Care to Immediate Family Members

- Provision of care to immediate family members. While there is significant confusion regarding the application of professional courtesy, CMS has further complicated the issue through rules regarding the provision of care to immediate family members. Pursuant to the Medicare Benefit Policy Manual, CMS bars “Medicare payment for items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge.”

- Who is excluded from coverage? CMS excludes from coverage any charges imposed by an immediate relative of a patient or member of the patient’s household (i.e., physician, therapist, supplier). These relationships include:
  - Husband and wife
  - Natural or adoptive parent, child, and sibling
  - Stepparent, stepchild, stepbrother, and stepsister
  - Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
  - Grandparents and grandchildren (either step or natural)

- Anybody else? Importantly, relationships that can trigger this exclusion of coverage also include members of a household, such as domestic employees and “others who live together as part of a single family unit.”
VIII: Provision of Care to Immediate Family Members.

- Group practice problems when applying the “immediate family member” rule. While these rules arguably make sense from a policy perspective, they don’t mesh well with the Anti-Kickback Statute, particularly when considering the rules in the context of physician group practices. CMS makes clear that this coverage exclusion applies to all physician services, including those services provided by a physician who is part of a professional corporation, such as a group practice.

- Problems encountered in a group setting. While these rules arguably make sense from a policy perspective, they don’t mesh well with the Anti-Kickback Statute, particularly when considering the rules in the context of physician group practices. CMS makes clear that this coverage exclusion applies to all physician services, including those services provided by a physician who is part of a professional corporation, such as a group practice.

IX: Gifts and the Anti-Kickback Statute

- Giving or receiving “Gifts” — Provider to Provider. Notably, when considering the issue of physician gifts, there is a fair degree of confusion among health care providers. Over the years, we have received numerous inquiries from providers who are under the false impression that physicians may give referring physicians up to $300 a year. This confusion appears to be generated by the fact that under Stark, a physician may receive up to $300 a year in non-monetary compensation (this amount is adjusted each year for inflation and is now $392 in 2016) from an entity which provides “designated health services.” Furthermore, they believe that this non-monetary compensation arrangement cannot violate the federal Anti-Kickback Statute or any other federal or state law. Don’t make this mistake. Even though certain conduct may be permissible under Stark, it is still imperative that you review an arrangement carefully to ensure that the practice does not run afoul of either the False Claims Act or the Anti-Kickback Statute.

- Any gift, regardless of its value, could be problematic under the Anti-Kickback Statute. If one purpose of the gift was to induce referrals, there is no “safe harbor” covering “the giving or receipt of gifts” under the Anti-Kickback Statute. Therefore, any gift to a referring physician could conceivably pose a certain degree of risk to both parties from a kickback standpoint.

IX: Gifts and the Anti-Kickback Statute

- Patients giving gifts or services to health care providers. In many communities, it is quite common for a grateful beneficiary or their family to send a gift to the patient’s treating physician or other provider. As reflected below in the AMA’s ethical opinion covering this situation, the AMA’s view is that gifts are often an expression of appreciation and gratitude or a reflection of cultural traditions, and can enhance the patient-physician relationship. Some gifts signal psychological needs that require the physician’s attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship. Physicians should make clear that giving them in excess of reasonable and customary value compromises their obligation to provide services in a fair manner. There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the propriety of accepting gifts, but the value relative to the patient’s or the physician’s means should not be disproportionately or inappropriately large. The patient should be informed that the physician will be more willing to prescribe an illicit drug, or other conduct which would clearly be questionable, such as gifts of cash. As the AMA ethical opinion covering this issue provides:

“Opinion 10.017 – Gift from Patients. Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician relationship. Some gifts signal psychological needs that require the physician’s attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship. Physicians should make clear that giving them in excess of reasonable and customary value compromises their obligation to provide services in a fair manner. There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the propriety of accepting gifts, but the value relative to the patient’s or the physician’s means should not be disproportionately or inappropriately large. The patient should be informed that the physician will be more willing to prescribe an illicit drug, or other conduct which would clearly be questionable, such as gifts of cash. As the AMA ethical opinion covering this issue provides:”
IX: Gifts and the Anti-Kickback Statute

- Health care providers giving gifts or services to beneficiaries. Generally, physicians should avoid giving gifts to patients. In fact, there are a number of federal and state laws which prohibit any gifts, payments, or other remuneration which is meant to influence a patient’s choice of provider.

- Notably, HHS-OIG has long expressed its concern regarding this issue. In August 2002, HHS-OIG issued its Special Advisory Bulletin titled “Offering Gifts and Other Inducements to Beneficiaries.” In the Bulletin, HHS-OIG identified a number of important principles in the document. One of the points made is that HHS-OIG will allow a health care provider to offer a Medicare or Medicaid beneficiary “inexpensive” gifts or services (other than cash or cash equivalents) without the offer or gift constituting a breach of the Anti-Kickback Statute. Notably, HHS-OIG considers an “inexpensive” gift to be one which has a retail value of no more than $10 apiece, with no more than $50 given to a patient in a given year.

- Our recommendation – Don’t give patients anything of value. In light of recent cases, we strongly recommend that providers not give anything of value, regardless of whether the gift is valued at less than $10.00.

IX: Gifts and the Anti-Kickback Statute

- Pharmaceutical representatives giving gifts to providers – 2002 PhRMA Code. In 2002, the Pharmaceutical Research and Manufacturers of America (PhRMA), a voluntary association of the country’s leading pharmaceutical research and biotechnology manufacturers, issued a new set of recommendations for its members. Known as the 2002 PhRMA Code, the guidance was intended to assist its members in self-regulating interactions between its sales representatives and physicians. Titled the “PhRMA Code on Interactions with Healthcare Professionals,” the PhRMA Code showed that the association had chosen to address the government’s concerns head-on rather than turn a blind eye to the improper marketing practices of its members. As the PhRMA Code expressly noted:

  "INDEPENDENCE OF DECISION MAKING

  No grants, scholarships, subsides, support, consulting contracts, or educational or practice related items should be provided or offered to a healthcare professional in exchange for prescribing products or for a commitment to continue prescribing products. Nothing should be offered or provided to a person or in conditions that would interfere with the independence of a healthcare professional’s prescribing practices.” (emphasis added).

- The 2002 PhRMA Code continued to allow for the giving of gifts valued at less than $100, as long as the items were “... primarily for the benefit of patients” and were not to be “offered on more than an occasional basis.” It also permitted pharmaceutical sales representatives to freely give items of “minimal value,” such as pens, calendars, and other “reminder items” to physicians, as long as the items benefited the medical practice.

IX: Gifts and the Anti-Kickback Statute


- One common practice—treating a health care provider and his or her staff members to a modest meal—was restricted by the 2002 PhRMA Code. Pursuant to the 2002 PhRMA Code, a complimentary meal could only be offered to facilitate a presentation or discussion with industry representatives and others speaking on behalf of the company. The mere “dropping off of meals” sometimes referred to as “drive and dash,” was prohibited by the 2002 PhRMA Code. No restriction as to the venue of the meal was instituted, however.

- The 2009 PhRMA Code changed that. While still allowing for the giving of meals, the PhRMA Code now requires that the meal “offered in connection with informational presentations made by field sales representatives or other authorized managers should be limited to in-office or in-hospital settings” (emphasis added). Out of office or hospital setting meals are only permitted in limited circumstances.
# X: Provision of Free and Discount Care

- **Free and discounted care.** The treatment of uninsured and underinsured patients is an area that has long been characterized by confusion and misinformation. Over the years, we have received numerous calls from clients asking if it is legal to provide free or discounted care and treatment to patients who are unable to pay full price.

- **Discounts provided for uninsured patients who cannot afford to pay their bills.** As HHS-OIG expressly provides in its 2004 guidance, “No OIG authority prohibits or restrains hospitals from offering discounts to uninsured persons who are unable to pay their hospital bills.” Additionally, HHS-OIG noted that no rule or regulation requires that a hospital engage in a particular collection practice. Moreover, a hospital is not precluded from giving discounts to uninsured patients (as long as the practice does not constitute a violation of the federal Anti-Kickback Statute or other federal enforcement requirement).

- **Reductions or waivers of Medicare cost-sharing amounts by providers for patients experiencing financial hardship.** As the 2004 guidance further provides, existing fraud and abuse laws do not prohibit a provider from waiving all or a portion of a beneficiary’s Medicare cost-sharing portion (deductible and/or co-payment) if the beneficiary qualifies as “financially needy.” As HHS-OIG’s guidance reflects, a good faith determination of “financial need” will vary, depending on the unique circumstances of each patient. Factors to be considered include, but are not necessarily limited to: (1) the local cost of living; (2) a patient’s income, assets, and expenses; (3) a patient’s family size; and (4) the scope and extent of a patient’s medical bills.

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**QUESTIONS**

This outline is provided as general information only. It does not constitute legal advice and should not be used as a substitute for seeking legal counsel. Robert W. Liles is an attorney with the Washington, DC / Baton Rouge, LA / Houston, TX / McAllen, TX firm of Liles Parker, PLLC. He may be contacted at (202) 288-8750 or by e-mail at rliles@lilesparker.com

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